**APPENDIX 3: SURVEY INSTRUMENTS**

**FY 2023 ANNUAL SURVEY OF HOSPITALS**

**FY 2023 HOSPITAL FISCAL SURVEY**

# ANNUAL SURVEY OF HOSPITALS TEMPLATE
## WHA Information Center

**NOTE:** Refer to the detailed instructions contained in the Annual Survey Manual.

This is a blank template to use to share the basic questions of the survey with other people in the organization in preparation for gathering all the necessary information to complete the online survey.

All survey data must be entered and submitted through the online secured portal. Each staff member completing a portion of the survey must have their own username and password. Click here for more information on roles and registration.

This information can also be printed from the survey portal.

*Disclaimer-the annual survey manual and the online portal contains the most accurate up-to-date information.

This template does not reference a specific year as all data is submitted through the online portal for the current year.

## I. GENERAL INFORMATION

**WHA Info Center 3-digit ID** _____          _____

Hospital Name _____

Address _____  P.O. Box _____

City, State _____  ZIP Code _____

| FY Beginning Date | | | FY Ending Date | | |
|---|---|---|---|---|---|
| ____ / | ____ / | ____ | ____ / | ____ / | ____ |
| Mo. | Day | Yr. | Mo. | Day | Yr. |

## II. HOSPITAL INFORMATION AND CLASSIFICATION

**Organization Information**

**1 Communications Contact and Reporting Period**

A. Identify the main primary contact responsible for communications related to the data.
B. Indicate the beginning of your current fiscal year.
C. Reporting period begin date.
D. Were you in operation 12 full months at the end of your reporting period?
   Yes---
   No---If no, number of days open during reporting period.

**Hospital / Organization Type**

**2** Indicate the type of organization responsible for establishing policy concerning overall hospital operation.
**CHECK ONLY ONE CODE**

| Government, Nonfederal | Non-government, Not-for-profit | Investor-owned For-profit | Government, Federal |
|---|---|---|---|
| ☐ 12 State | ☐ 21 Religious organization | ☐ 31 Individual | ☐ 45 Veterans Affairs |
| ☐ 13 County | ☐ 23 Other not-for-profit | ☐ 32 Partnership | |
| ☐ 14 City | | ☐ 33 Corporation | |

**3** Is the hospital part of a health care system? ........ ☐ Yes ☐ No
If YES, give name, city, and state of the system headquarters.

*(Name)* _____ *(City)* _____ *(State)* _____

**4** Is the hospital a division or subsidiary of a holding company? ........ ☐ Yes ☐ No

**5** Does the hospital itself operate subsidiary corporations? ........ ☐ Yes ☐ No

**6** Is the hospital contract managed? ........ ☐ Yes ☐ No
If YES, give name, city, and state of organization that manages the hospital.

*(Name)* _____ *(City)* _____ *(State)* _____

**7** Is the hospital a member of an alliance? ........ ☐ Yes ☐ No
If YES, give name, city, and state of the alliance headquarters. **If more than one, list in Section XIV.**

*(Name)* _____ *(City)* _____ *(State)* _____

**8** Is the hospital a participant in a health care network? ........ ☐ Yes ☐ No
If YES, give name, city, and state of the network headquarters. **If more than one, list in Section XIV.**

*(Name)* _____ *(City)* _____ *(State)* _____

**9** Does the hospital participate in a group purchasing arrangement? ........ ☐ Yes ☐ No
If YES, give name, city, and state of the group purchasing organization.

*(Name)* _____ *(City)* _____ *(State)* _____

**10** Does the hospital own or operate a primary group practice? ........ ☐ Yes ☐ No

**Service**

**11** Indicate the ONE category that BEST describes the type of service that the hospital provides to the MAJORITY of admissions.

☐ 10 General medical and surgical   ☐ 22 Psychiatric
☐ 15 GMS – Critical Access Hospital   ☐ 46 Rehabilitation

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☐ 20 GMS – Long-Term Acute Care    ☐ 82 Alcohol/Substance Use Disorder

**12** Does the hospital restrict admissions primarily to children? ................................................ ☐ Yes    ☐ No

**Accreditation** (Check all that apply). *Note for "Other," do not specify State of Wisconsin*

**13**
☐ The Joint Commission        ☐ AOA        ☐ Title 18 certified and HFS 124 licensed

☐ Date of last survey          ☐ DNV        ☐ DHS 124 licensed
__/__ (mm/yy)

                                             ☐ Other (specify) _____

**Certification Status**
**If more than one provider number, list in Section XIV.**

**14** Medicare (Title 18) ................................................................................... ☐ Yes    ☐ No

If YES, **Provider Number**     52 - ____  ____  ____  ____

**15** Medicaid (Title 19) .................................................................................... ☐ Yes    ☐ No

If YES, **Provider Number**     ____  ____ - ____  ____  ____  ____  ____  ____

**Managed Care Information**

Does the hospital have a formal written contract that specifies the obligations of each party with:

**16** Health Maintenance Organization *(HMO)*? ........................... ☐ Yes    ☐ No  **If Yes,** how many contracts? [____]

**17** Preferred Provider Organization *(PPO)*? ........................... ☐ Yes    ☐ No  **If Yes,** how many contracts? [____]

**18** Other managed care or prepaid plan? ................................ ☐ Yes    ☐ No  **If Yes,** how many contracts? [____]

**19** Indicate whether any of the following insurance products have been developed by the hospital, health care system, network, or jointly owned with an insurer *(check all that apply)*:

|  | (1)<br>Hospital | (2)<br>Health Care System | (3)<br>Network | (4)<br>Jointly Owned With Insurer |
|---|---|---|---|---|
| Health Maintenance Organization | ☐ | ☐ | ☐ | ☐ |
| Preferred Provider Organization | ☐ | ☐ | ☐ | ☐ |
| Indemnity Fee-for-Service Plan | ☐ | ☐ | ☐ | ☐ |

**20** What percentage of the hospital's NET patient revenue is paid on a capitated basis? [_____ %]
(If the hospital does not participate in capitated arrangements, **enter "0."**)     (Round; do not use decimals.)

**21** Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared-risk basis? ......................................................... ☐ Yes    ☐ No

**22** If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated premium, how many lives are covered? [_____]

**Criteria to Determine If Nursing Home Data Should Be Submitted**

23 Does the hospital own and operate a nursing home facility under HFS 132? ................................. ☐ Yes ☐ No
   **If YES**, answer the question on line 24.

24 Are the hospital and nursing home governed by a common Board of Directors? ............................... ☐ Yes ☐ No

25 If answers to both 23 and 24 are YES, check the appropriate box regarding the location of the nursing home facility.

Attached/within hospital ☐          Freestanding on hospital campus ☐          Freestanding off campus ☐

**III. SELECTED INPATIENT UNITS**

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**If information for a category is zero, fill in 0.  If information for a category is Not Applicable, fill in 0.  Do NOT use dashes, NA, N/AV, or M.**

---

Account for all adult and pediatric inpatient beds set-up-and-staffed on the last day of the fiscal year (*excluding weekends or holidays*).  Do not include "normal newborn" bassinets.  List beds for a line only if a unit is specifically designated for the service area.  The number of discharges should include deaths and unit transfers.  For each service listed, circle the code number (*see codes 1-5 below*) that best describes the status of the service as of the last day of the fiscal year.

| Code | Description |
|---|---|
| 1 | **Service is provided in or by the hospital in a DISTINCT AND SEPARATE UNIT.  The number of beds and utilization information MUST be provided for inpatient units.** |
| 2 | **Service is provided in or by the hospital but NOT IN A DISTINCT AND SEPARATE UNIT.** |
| 3 | **Service is provided by the hospital's Health Care System.** |
| 4 | **Service IS NOT MAINTAINED by the hospital but is available, in the hospital or another facility, through a FORMAL CONTRACTUAL arrangement with another hospital or provider, including networks and joint ventures.** |
| 5 | **SERVICE NOT AVAILABLE either by the hospital or through a formal contractual arrangement with another hospital or provider.** |

| Code | Description |
|---|---|
| O | **Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under.** |
| B | **Service is provided by the hospital IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING ).** |
| NOTE: | If the hospital has beds of more than one type in a mixed unit, all bed and utilization data for all bed types found in that unit should be reported on the line corresponding to the mixed unit. Code the "mixed unit" with a "1," and code each individual bed type line for that unit with a "2."

Example: If "Mixed intensive care" is the main unit for intensive care beds, code it "1" and the types of beds that may be found there "2." All bed and utilization data should be reported on line 40, "Mixed intensive care."

**For a unit coded "2," utilization may be reported only if beds, discharges, and inpatient days are all available.** |

**26**  Are any patient services provided by the hospital in buildings other than the main hospital bldg
.................................................................................................  ☐ Yes      ☐ No

If YES, enter address(es) of other buildings:
In addition to circling code numbers 1-5, **circle O or B, if applicable.  See Instructions.**

| Selected Inpatient Units | Beds-set-up-&-staffed last day of fiscal year | Number of discharges / transfers for fiscal year | Inpatient days for fiscal year | Discharge Days | Circle one for each line | O or B |
|---|---|---|---|---|---|---|
| **GENERAL MEDICAL/SURGICAL** | | | | | | |
| 27 **Adult Medical / Surgical, Acute** (include gynecology)........... | | | | | 1 2 3 4 5 | |
| 28 **Orthopedic** ............... | | | | | 1 2 3 4 5 | |
| 29 **Rehabilitation and Physical Medicine** ..... | | | | | 1 2 3 4 5 | |
| 30 **Hospice** ................. | | | | | 1 2 3 4 5 | |
| 31 **Acute Long–Term Care** (Hospital Only) | | | | | 1 2 3 4 5 | |
| 32 **All Other Acute** (Specify types) [_____]........... | | | | | 1 2 3 4 5 | |
| 33 **Pediatrics** General Medical/Surgical ...... | | | | | 1 2 3 4 5 | |
| 34 **Obstetrics** Level of care (1, 2 or 3) [____] (include LDRP, exclude gynecology)...... | | | | | 1 2 3 4 5 | |
| 35 **Psychiatric Inpatient Care** Inpatient Care ............. | | | | | 1 2 3 4 5 | |
| 36 **Alcohol/Substance Use Disorder** Inpatient Care ................. | | | | | 1 2 3 4 5 | |
| **ICU/CCU** | | | | | | |
| 37 **Medical / Surgical Intensive Care** ....... | | | | | 1 2 3 4 5 | |
| 38 **Cardiac Intensive Care** ................ | | | | | 1 2 3 4 5 | |
| 39 **Pediatric Intensive Care** ................ | | | | | 1 2 3 4 5 | |
| 40 **Burn Care** ............... | | | | | 1 2 3 4 5 | |
| 41 **Mixed Intensive Care** ............... | | | | | 1 ■ 3 4 5 | |
| 42 **Step-down** (special care) ............... | | | | | 1 2 3 4 5 | |

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| Selected Inpatient Units | Beds-set-up-&-staffed last day of fiscal year | Number of discharges / transfers for fiscal year | Inpatient days for fiscal year | Discharge Days | Circle one for each line | O or B |
|---|---|---|---|---|---|---|
| **43** **Neonatal Intensive / Intermediate Care** *(exclude normal newborns)* .............. | | | | | 1 2 3 4 5 | |
| **44** **All Other Intensive Care** [specify type(s)] | | | | | 1 2 3 4 5 | |
| **45** **Subacute Care** Inpatient care ..................... | | | | | 1 2 3 4 5 | |
| **46** **ALL OTHER INPATIENT UNITS** [specify treatment area(s)] | | | | | 1 2 3 4 5 | |
| **47** **TOTAL HOSPITAL FACILITY** (**Exclude** Medicare-certified swing bed inpatient days and Non-Medicare-certified, swing-bed inpatient days). ..................... | (add lines 27-46) | (add lines 27-46) | (add lines 27-46) | (add lines 27-46) | | |
| **48** **MEDICARE-CERTIFIED SWING UNIT** (Medicare patients only) (Report **average** number of beds used, rounded to whole number) | (average # beds used) | (discharges and transfers) | (inpatient days) | (discharge days) | 1 2 3 4 5 | |
| **49** **NON- MEDICARE-CERTIFIED SWING UNIT** (Non-Medicare patients only) (Report **average** number of beds used, rounded to whole number) | (average # beds used) | (discharges and transfers) | (inpatient days) | (discharge days) | 1 2 3 4 5 | |
| **50** **Newborn Nursery** (Bassinets and utilization should be reported on lines 155-157) | | | | | 1 2 3 4 5 | |

**IV. SELECTED ANCILLARY AND OTHER SERVICES**

|  | | Circle One | O or B |
|---|---|---|---|

For each service, circle the code number that best describes the status of the service as of the last day of the fiscal year, except weekends and holidays.

| | | Circle One | O or B |
|---|---|---|---|
| 51 | AIDS/HIV – Specialized Outpatient Program for AIDS/HIV | 1 2 3 4 5 | _____ |
| 52 | Alcohol/Substance Use Disorder Outpatient Services *(psych/social)* | 1 2 3 4 5 | _____ |
| | **Ambulance/Transportation Services- Non-emergency** | | |
| 53 | - **Non-emergency** inter-facility transports by ground ambulance | 1 2 3 4 5 | _____ |
| 54 | - **Non-emergency** inter-facility transports by air ambulance | 1 2 3 4 5 | _____ |
| 55 | Arthritis Treatment Center | 1 2 3 4 5 | _____ |
| 56 | Assisted Living | 1 2 3 4 5 | _____ |
| 57 | Volunteer (Auxiliary) Services Department | 1 2 3 4 5 | _____ |
| 58 | Bariatric Services:  Bariatric Weight | 1 2 3 4 5 | _____ |
| 59 | Birthing Room/Labor, Delivery, Recovery, Post-partum Room (LDR or LDRP room) | 1 2 3 4 5 | _____ |
| | **Cardiac services** | | |
| 60 | - Cardiac Angioplasty *(percutaneous transluminal)* | 1 2 3 4 5 | _____ |
| 61 | - Cardiac Catheterization Laboratory | 1 2 3 4 5 | _____ |
| 62 | - Cardiac Rehabilitation Program | 1 2 3 4 5 | _____ |
| 63 | - Non-invasive Cardiac Assessment Services | 1 2 3 4 5 | _____ |
| 64 | - Open-heart Surgery | 1 2 3 4 5 | _____ |
| 65 | Case Management | 1 2 3 4 5 | _____ |
| 66 | Violence (Crisis) prevention programs in workplace and community | 1 2 3 4 5 | _____ |
| 67 | Complementary Services | 1 2 3 4 5 | _____ |
| 68 | Dental Services | 1 2 3 4 5 | _____ |
| | **Dialysis services:** | | |
| 69 | - Hemodialysis | 1 2 3 4 5 | _____ |
| 70 | - Peritoneal dialysis | 1 2 3 4 5 | _____ |
| | **Emergency/urgent care:** | | |
| 71 | - Emergency Department *(general medical and surgical)* | 1 2 3 4 5 | _____ |
| 72 | - Trauma Center     **[ Self-designated Level          ]** | 1 2 3 4 5 | _____ |
| 73 | - Urgent Care Center | 1 2 3 4 5 | _____ |
| 74 | Ethics Committee | 1 2 3 4 5 | _____ |

| | | Circle One | O or B |
|---|---|---|---|
| 75 | Extracorporeal Shock Wave Lithotripter *(ESWL)* **CHECK ONE**     Fixed     Mobile | 1 2 3 4 5 | |

| | *Selected Ancillary and Other Services* | **Circle One** | **O or B** |
|---|---|---|---|
| 76 | Fitness Center | 1 2 3 4 5 | _____ |
| | **Food service** | | |
| 77 | - Meals on Wheels | 1 2 3 4 5 | _____ |
| 78 | - Nutrition Programs | 1 2 3 4 5 | _____ |
| 79 | Genetic Counseling/Screening | 1 2 3 4 5 | _____ |
| | **Geriatric services** | | |
| 80 | - Adult Day Care Program | 1 2 3 4 5 | _____ |
| 81 | - Alzheimer's Diagnosis/Assessment | 1 2 3 4 5 | _____ |
| 82 | - Comprehensive Geriatric Assessment | 1 2 3 4 5 | _____ |
| 83 | - Emergency Response System | 1 2 3 4 5 | _____ |
| 84 | - Geriatric Acute Care Unit | 1 2 3 4 5 | _____ |
| 85 | - Geriatric Clinics | 1 2 3 4 5 | _____ |
| 86 | - Respite Care | 1 2 3 4 5 | _____ |
| 87 | - Retirement Housing | 1 2 3 4 5 | _____ |
| 88 | - Senior Membership Program | 1 2 3 4 5 | _____ |
| | **Health Promotion** | | |
| 89 | - Community Health Promotion | 1 2 3 4 5 | _____ |
| 90 | - Patient Education | 1 2 3 4 5 | _____ |
| 91 | - Worksite Health Promotion | 1 2 3 4 5 | _____ |
| 92 | Home Health Services | 1 2 3 4 5 | |
| 93 | Home Hospice Services | 1 2 3 4 5 | _____ |
| | **Mammography services** | | |
| 94 | - Diagnostic Mammography | 1 2 3 4 5 | _____ |
| 95 | - Mammography Screening | 1 2 3 4 5 | _____ |
| 96 | Occupational Health Services | 1 2 3 4 5 | _____ |
| | **Occupational, physical, and/or rehabilitation services** | | |
| 97 | - Audiology | 1 2 3 4 5 | _____ |
| 98 | - Occupational Therapy | 1 2 3 4 5 | _____ |
| 99 | - Physical Therapy | 1 2 3 4 5 | _____ |

| | *Selected Ancillary and Other Services* | Circle One | O or B |
|---|---|---|---|
| **100** | - Recreational Therapy | 1 2 3 4 5 | _____ |
| **101** | - Rehabilitation Inpatient Services *(service does not have beds)* | 1 2 3 4 5 | _____ |
| **102** | - Rehabilitation Outpatient Services | 1 2 3 4 5 | _____ |
| **103** | - Respiratory Therapy | 1 2 3 4 5 | _____ |
| **104** | - Speech Pathology / Therapy | 1 2 3 4 5 | _____ |
| **105** | Oncology Services | 1 2 3 4 5 | _____ |
| **106** | - Outpatient services – within the hospital | 1 ▋ 3 4 5 | _____ |
| **107** | - Outpatient services – on hospital campus, but in freestanding center | 1 ▋ 3 4 5 | _____ |
| **108** | - Outpatient services – freestanding off hospital campus | 1 2 3 4 5 | _____ |
| **109** | Pain Management Program | 1 2 3 4 5 | _____ |
| **110** | Patient Representative Services | 1 2 3 4 5 | _____ |

**Psychiatric services**

| | | Circle One | O or B |
|---|---|---|---|
| **111** | - Psychiatric Child / Adolescent Services | 1 2 3 4 5 | _____ |
| **112** | - Psychiatric Consultation – Liaison Services | 1 2 3 4 5 | _____ |
| **113** | - Psychiatric Education Services | 1 2 3 4 5 | _____ |
| **114** | - Psychiatric Emergency Services | 1 2 3 4 5 | _____ |
| **115** | - Psychiatric Geriatric Services | 1 2 3 4 5 | _____ |
| **116** | - Psychiatric Outpatient Services | 1 2 3 4 5 | _____ |
| **117** | - Psychiatric Partial Hospitalization Program | 1 2 3 4 5 | _____ |
| **118** | Radiation Therapy | 1 2 3 4 5 | _____ |

**Radiology, diagnostic**

| | | Circle One | O or B |
|---|---|---|---|
| **119** | - CT Scanner (*Computed Tomagraphic Scanner*) | 1 2 3 4 5 | _____ |

Check One:  ☐ Fixed  ☐ Mobile  ☐ Both

| | | Circle One | O or B |
|---|---|---|---|
| **120** | - Nuclear Medicine Department | 1 2 3 4 5 | _____ |
| **121** | - Magnetic Resonance Imaging (*MRI*) | 1 2 3 4 5 | _____ |

Check One:  ☐ Fixed  ☐ Mobile  ☐ Both

| | | Circle One | O or B |
|---|---|---|---|
| **122** | - Positron Emission Tomography Scanner (*PET*) | 1 2 3 4 5 | _____ |
| **123** | - Single Photon Emission Computerized Tomography (*SPECT*) | 1 2 3 4 5 | _____ |

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Check One: ☐ **Fixed**  ☐ **Mobile**  ☐ **Both**

| | | | |
|---|---|---|---|
| **124** | - Ultrasound | 1 2 3 4 5 | _____ |

**Reproductive health**

| | | | |
|---|---|---|---|
| **125** | - Fertility Counseling | 1 2 3 4 5 | _____ |
| **126** | - In Vitro Fertilization | 1 2 3 4 5 | _____ |
| **127** | Social Work Services | 1 2 3 4 5 | _____ |
| **128** | Sports Medicine Clinic/Services | 1 2 3 4 5 | _____ |
| **129** | Surgery, Ambulatory or Outpatient *(day surgery)* | 1 2 3 4 5 | _____ |

**Telemedicine**

| | | | |
|---|---|---|---|
| **130** | Teleradiology or Other Store and Forward Services | 1 2 3 4 5 | _____ |
| **131** | Tele ICU | 1 2 3 4 5 | _____ |
| **132** | Tele Stroke | 1 2 3 4 5 | _____ |
| **133** | Tele Psychiatry | 1 2 3 4 5 | _____ |
| **134** | E-Visits | 1 2 3 4 5 | _____ |
| **135** | Remote Patient Monitoring | 1 2 3 4 5 | _____ |
| **136** | Specialist Consultation | | _____ |

**Transplant services**

| | | | |
|---|---|---|---|
| **137** | - Bone Marrow Transplant Program | 1 2 3 4 5 | _____ |
| **138** | - Heart and/or Lung Transplant | 1 2 3 4 5 | _____ |
| **139** | - Kidney Transplant | 1 2 3 4 5 | _____ |
| **140** | - Tissue Transplant | 1 2 3 4 5 | _____ |
| **141** | Women's Health Center/Services | 1 2 3 4 5 | _____ |

**142** Are additional non-listed **patient** services provided by the hospital? ..................................... ☐ Yes ☐ No
If YES, list and indicate with O or B if provided in other buildings
*(If more room is needed, go to Section XIV)*

**143** If **O** or **B** is used on lines **27-141**, indicate the number of locations and the address(es) and service(s) provided. *(If more room is needed, go to Section XIV.)*

Number of other locations ☐

| Street address _____ | Street address _____ |
| City _____ | City _____ |
| Service _____ Line _____ | Service _____ Line _____ |
| Service _____ Line _____ | Service _____ Line _____ |
| Service _____ Line _____ | Service _____ Line _____ |

**144** Does the hospital have provider-based facilities that are billed using the hospital's Medicare provider number, reported on Line 14? .......................................................................... ☐ Yes ☐ No

If YES, indicate the number of facilities. ☐

If YES, indicate the street address and city. *(If more than one address, go to Section XII.)*

Street address _____

City _____

## V. SELECTED SERVICE UTILIZATION

**DO NOT SKIP THIS PAGE.  FILL IN ALL LINES.**

> If information for a category is zero, fill in 0.
> If information for a category is Not Applicable, fill in 0.
> Do NOT use dashes, N/A, N/AV, or M.

### Surgical Operations *(whether major or minor)*

145 Inpatient surgical operations *(not procedures)* .................................................... _____

146 Outpatient surgical operations *(not procedures)* ................................................. _____

147 TOTAL surgical operations *(not procedures)* [line 145 + line 146] ........................ _____

### Outpatient Visits

148 Emergency visits ................................................................................................. _____

   -Number of emergency visits that resulted in inpatient admissions  (Subset of line 148) [_____]

149 Other visits *(all non-emergency visits, including urgent care, physician referrals and outpatient surgeries)* .................. _____

150 Observation visits ............................................................................................... _____

151 TOTAL outpatient visits [Add *Line 148 + Line 149 + Line 150*] ............................ _____

### Non-emergency Ambulance/Transport Services

152 Non-emergency inter-facility transports by ground ambulance ............................. _____

153 Non-emergency inter-facility transports by air ambulance ................................... _____

154 TOTAL non-emergency transports by ambulance [*Add Line 152 + Line 153*] ............ _____

### Newborn Nursery

155 Number of bassinets set-up-and-staffed as of the last day of the fiscal year *(exclude neonatal beds )* ............................................. _____

156 Total births *(exclude fetal deaths)* ..................................................................... _____

157 Newborn days *(exclude neonatal days )* .............................................................. _____

## VI. TOTAL FACILITY UTILIZATION AND BEDS

> **DO NOT USE DASHES, N/A, N/AV, OR M.**
> **IF INFORMATION FOR A CATEGORY IS ZERO, FILL IN 0.**
> **IF INFORMATION FOR A CATEGORY IS NOT APPLICABLE, FILL IN 0.**
> **DO NOT MAKE ALTERATIONS TO SURVEY QUESTIONS**

**Utilization and Beds**

| | (1) Hospital | (2) Nursing Home | |
|---|---|---|---|
| **158** Admissions *(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)* | _____ | _____ | |
| **159** Inpatient days *(exclude newborns; include Medicare-certified and Non-Medicare swing days)* | _____ | _____ | Skilled nursing |
| | | _____ | Intermediate care |
| | | _____ | Residential / Elderly housing |
| **160** Discharges/Deaths *(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)* | _____ | _____ | |
| **161** Census [*The number of inpatients occupying beds at midnight on the last day (****exclude weekends or holidays****) of the fiscal year. Exclude newborns; include Medicare-Certified and Non-Medicare swing patients.*] | _____ | _____ | |

**Utilization and Beds**

**Indicate Beds set-up-and-staffed** (**NOT number of licensed beds**) on the last day *excluding weekends or holidays*) of the hospital's fiscal year quarter *(every 3 months)*.

| | (1) Hospital | (2) Nursing Home | |
|---|---|---|---|
| **162** 1st Quarter | _____ | _____ | Skilled nursing |
| | | _____ | Residential / Elderly housing |
| **163** 2nd Quarter | _____ | _____ | Skilled nursing |
| | | _____ | Residential / Elderly housing |
| **164** 3rd Quarter | _____ | _____ | Skilled nursing |
| | | _____ | Residential / Elderly housing |
| **165** 4th Quarter (Hospital beds must equal line 47, col.1) | _____ | _____ | Skilled nursing |
| | | _____ | Residential / Elderly housing |

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**Utilization and Beds**

|  | (1) Hospital | (2) Nursing Home |
|---|---|---|

**Medicare / Medicaid Primary Payer Utilization**

**166**    Total Medicare *(Title 18)* **Inpatient Discharges** _____    _____

**167**    Total Medicare (Title 18) **Outpatient Visits** _____

**168**    Total Medicare Inpatient **Days** _____    _____

**169**    Total Medicaid *(Titles 19 & 21)* **Inpatient Discharges** _____    _____

**170**    Total Medicaid (*Titles 19 & 21)* **Outpatient Visits** _____

**171**    Total Medicaid Inpatient **Days** _____    _____
*(Exclude newborns; include Medicare-certified swing bed utilization, . Include T-18 and T-19 HMO utilization.)*

### VII.    MEDICAL STAFF – September 30.

Indicate which of the following physician arrangements the hospital, health care system, and/or network participate in:

| | Hospital | Health Care System | Network |
|---|---|---|---|
| **172** Independent practice association (IPA) | ☐ # physicians: _____ | ☐ | ☐ |
| **173** Group practice without walls | ☐ # physicians: _____ | ☐ | ☐ |
| **174** Open Physician Hospital Organization (PHO) | ☐ # physicians: _____ | ☐ | ☐ |
| **175** Closed Physician Hospital Organization (PHO) | ☐ # physicians: _____ | ☐ | ☐ |
| **176** Management Service Organization (MSO) | ☐ # physicians: _____ | ☐ | ☐ |
| **177** Integrated Salary Model | ☐ # physicians: _____ | ☐ | ☐ |
| **178** Equity Model | ☐ # physicians: _____ | ☐ | ☐ |
| **179** Foundation | ☐ # physicians: _____ | ☐ | ☐ |
| **180** Accountable Care Organization (ACO) | ☐ # physicians: _____ | ☐ | ☐ |
| **181** Other | ☐ # physicians: _____ | ☐ | ☐ |

**Selected Specialty**

| | If information for a category is zero, fill in 0.<br>If information for a category is Not Applicable, fill in 0. Do NOT use dashes, N/A, N/AV, or M. | |
|---|---|---|

| Active/Associate Medical Staff | (1)<br>Medical Staff **as of Sept. 30**<br>*(Includes Board Certified)* | (2)<br>Board Certified Staff<br>**As of Sept. 30** |
|---|---|---|
| | | *[Not to exceed column (1)]* |

**Medical Specialties**

**182**  General and Family Practice ....................  _____  _____

**183**  Internal Medicine *(general)* ..........................  _____  _____

**184**  Internal Medicine *subspecialties* ....................  _____  _____

**185**  Pediatrics *(general)* ..........................  _____  _____

**186**  Pediatric *subspecialties* ..........................  _____  _____

**Surgical Specialties**

**187**  General Surgery ..........................  _____  _____

**188**  Obstetrics/Gynecology ..........................  _____  _____

**189**  All other surgical *specialties* ..........................  _____  _____

**Other**

**190**  Anesthesiology ..........................  _____  _____

**191**  Emergency Medicine ..........................  _____  _____

**192**  Pathology ..........................  _____  _____

**193**  Radiology ..........................  _____  _____

**194**  Addiction Medicine ..........................  _____  _____

**195**  Psychiatry ..........................  _____  _____

**196**  All other specialties *(use valid specialties below)* ....................  _____  _____

*Line 197 - codes for valid specialties- check all codes that apply:*

☐ Aerospace Medicine     ☐ General Preventive Medicine     ☐ Podiatry

☐ Chiropractic Services     ☐ Nuclear Medicine     ☐ Physical Med&Rehab (includes Physiatry)

☐ Dental     ☐ Occupational Medicine     ☐ Public health

**198**  **TOTAL** Medical Staff ..........................  _____  _____
| | (add lines 182-196) | (add lines 182-196) |

## VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30 - DATA FOR ONE WEEK ONLY.

Report the number of full-time and part-time personnel, **including trainees**, in the categories specified below.  Report part-time hours for each category.  All data must be for **the week of September 30, regardless of the hospitals' fiscal year end date.** Treat shared hospital/nursing home staff as part-time and report only hospital hours. **Do not include contracted staff or nursing home** personnel.

**DO NOT USE DASHES, N/A, N/AV, OR M.**
**PLEASE ROUND TO NEAREST WHOLE NUMBER.  DO NOT USE DECIMALS.**

| Occupational Categories | FULL TIME Total No. of Persons (35 Hr/Wk or more) | PART TIME Total No. of Persons (less than 35 Hr/Wk) | Total No. of P-T hours (week of Sept 30) |
|---|---|---|---|
| 199 Administrators and assistant administrators | | | |
| **Physician And Dental Services** | | | |
| 200 Physicians / Dentists | | | |
| 201 Dental Hygienists | | | |
| 202 Hospitalists | | | |
| 203 **Please select the category below that best describes the employment model for your hospitalists.** | | | |

☐ Independent provider group      ☐ Employed by a university or school program
☐ Employed by a physician group      ☐ Other
☐ Employed by your hospital

| Occupational Categories | FULL TIME | PART TIME | P-T hours |
|---|---|---|---|
| 204 Intensivists | | | |
| 205 Medical and dental residents/interns | | | |
| **Nursing Services** | | | |
| 206 Registered nurses | | | |
| 207 Certified nurse midwives | | | |
| 208 Licensed practical *(vocational)* nurses | | | |
| 209 Paraprofessionals: Nursing Assistants (CNA) | | | |
| 210 Medical assistants | | | |
| 211 Physician assistants | | | |
| 212 Nurse practitioners | | | |
| 213 Pharmacists | | | |
| 214 Pharmacy Technician/Aides | | | |
| 215 Medical & Clinical Laboratory Technologists | | | |
| 216 Medical & Clinical Laboratory Technicians | | | |
| 217 Surgical Technologists & Technicians | | | |
| 218 Certified registered nurse anesthetists | | | |
| 219 Clinical Nurse Specialists | | | |
| **Therapeutic Services** | | | |
| 220 Respiratory Therapists | | | |
| 221 Radiologic Technologists | | | |

| Occupational Categories (*continued*) | FULL TIME Total No. of Persons (*35 Hr/Wk or more*) | PART TIME Total No. of Persons (*less than 35 Hr/Wk*) | Total No. of P-T hours (*week of Sept 30*) |
|---|---|---|---|
| 222 Sonographer | | | |
| 223 All other Radiologic Personnel | | | |
| 224 Occupational Therapists | | | |
| 225 Occupational therapy assistants/aides | | | |
| 226 Physical therapists | | | |
| 227 Physical therapy assistants/aides | | | |
| 228 Recreational therapists | | | |
| 229 Health Information Management Administrators/Technicians | | | |
| 230 Dieticians and Nutritionists | | | |
| **Psychology / Social Work Services** 231 Psychologists | | | |
| 232 Social Workers | | | |
| **Other Personnel** 233 All other health professional / technical personnel | | | |
| 234 All other personnel | | | |
| 235 **TOTAL** hospital personnel | (add lines 199-234) | (add lines 199-234) | (add lines 199-234) |

236 **Workweek**
Indicate the **average or definition of** WORKWEEK (number of hours per week) of the full-time employees engaged in direct patient care (**40, 38, 35**, etc.) **Do not use decimals.**

(Average **full-time** hours per week)

## IX. OTHER (*Lines 237-245*)

Check the appropriate box to indicate the answer to each question.

237 Does your hospital's mission statement include a focus on community benefit? ☐ Yes ☐ No

238 Does your hospital have a long-term plan for improving the health status of its community? ☐ Yes ☐ No

239 Does your hospital have resources for its community benefit activities? ☐ Yes ☐ No

240 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community? ☐ Yes ☐ No

241 Does your hospital use health status indicators (*such as rates of health problems or surveys of self-reported health*) for defined populations to design new services or modify existing services? ☐ Yes ☐ No

242 Does your hospital work with other local providers, public agencies, or community representatives to conduct/develop a written health status assessment of the needed capacity for health services in the community? ☐ Yes ☐ No

243 **IF YES,** have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community? ☐ Yes ☐ No

244 Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations? ☐ Yes ☐ No

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**245** Does your hospital either by itself or in conjunction with others disseminate reports to the community on the comparative quality and costs of health care services? ..................................................................... ☐ Yes ☐ No

## X. SERVICE QUALITY / PATIENT SAFETY

**246** **Please identify the amount of resources allocated to quality and risk management functions. If a position is split between two or more roles, indicate the portion of the FTE dedicated to each function.**

|  | **Dedicated FTEs** |
|---|---|
| Quality management & improvement | _____ |
| Clinical safety | _____ |
| Case management | _____ |
| Accreditation | _____ |
| Infection control | _____ |
| Risk Management | _____ |

**247** Does your facility provide 24-hour pharmacy services?

☐ Yes    ☐ No

## XI. E-HEALTH
Please indicate if you have the following features fully implemented, partially implemented, in the planning process, or not at all with your facility's electronic health record implementation.
.

| | Feature | Fully Implemented | Partially Implemented | Planning | Not at All |
|---|---|---|---|---|---|
| **248** | Core MPI database with admission/discharge/transfer | ☐ | ☐ | ☐ | ☐ |
| **249** | Lab information system | ☐ | ☐ | ☐ | ☐ |
| **250** | Pharmacy system | ☐ | ☐ | ☐ | ☐ |
| **251** | E-MAR (real-time enterprise medication administration record) | ☐ | ☐ | ☐ | ☐ |
| **252** | Medication dispensing | ☐ | ☐ | ☐ | ☐ |
| **253** | RIS (Radiology information system) | ☐ | ☐ | ☐ | ☐ |
| **254** | Computerized radiography (digital x-ray) | ☐ | ☐ | ☐ | ☐ |
| **255** | PACS (Picture archiving and communication system) | ☐ | ☐ | ☐ | ☐ |
| **256** | Order entry/resulting | ☐ | ☐ | ☐ | ☐ |
| **257** | Inpatient charting | ☐ | ☐ | ☐ | ☐ |
| **258** | Bedside medication verification | ☐ | ☐ | ☐ | ☐ |
| **259** | CPOE (Computerized physician order entry) | ☐ | ☐ | ☐ | ☐ |
| **260** | EHR portal | ☐ | ☐ | ☐ | ☐ |
| **261** | Bulk scanning | ☐ | ☐ | ☐ | ☐ |

| | Feature | Fully Implemented | Partially Implemented | Planning | Not at All |
|---|---|---|---|---|---|
| 262 | Surgery management system | ☐ | ☐ | ☐ | ☐ |
| 263 | Interface engine/expertise | ☐ | ☐ | ☐ | ☐ |
| 264 | Physician Practice Management Systems | ☐ | ☐ | ☐ | ☐ |
| 265 | Physician Practice EMR Systems | ☐ | ☐ | ☐ | ☐ |
| 266 | Long Term Care EMR System | ☐ | ☐ | ☐ | ☐ |
| 267 | Home Health EMR System | ☐ | ☐ | ☐ | ☐ |

## XII. HEALTH INFORMATION TECHNOLOGY

**Expenditures**

268     Total Health Information Technology Expenditures - Capital     $_____

269     Total Health Information Technology Expenditures- Operating   $_____

270     **What type of internet connection comes into your hospital?**

☐ T1
☐ T3
☐ A telephone company DSL line (high speed)
☐ A fiber-optic connection
☐ Other
   If Other, please explain:

## XIII. SOCIAL DETERMINANTS OF HEALTH (SDOH)

271     Does your facility screen patients for social needs?

   Yes, for all patients   Yes, for some patients   No, (skip to question 274)

272     If yes, please indicate which social needs are assessed.  (Check all that apply)

☐ Housing (instability, quality, financing)
☐ Food insecurity or hunger
☐ Utility Needs
☐ Interpersonal violence
☐ Transportation
☐ Employment and income
☐ Education
☐ Social isolation (lack of family and social support)
☐ Health behaviors

Other, please describe _____

273     If yes, does your facility record the social needs screening results in your EHR?

   Yes      No

**274**  Does your facility utilize outcome measures (for example, cost of care or readmission rates) to assess the effectiveness of the interventions to address patients' social needs?

Yes        No

**275**  Has your facility been able to gather data indicating that activities used to address the SDOH and patient social needs have resulted in any of the following? (Check all that apply)

- [ ] Better health outcomes for patients
- [ ] Decreased utilization of hospital or health system services
- [ ] Decreased health care costs
- [ ] Improved community health status

**276**  Who in your hospital or health care system is accountable for **meeting** health equity goals (Check all that apply)
a.CEO
b.Designated Senior Executive (Chief Diversity Officer, VP for DEI, etc.)
c.Middle Management
d.Committee or Task Force
e.Division/Department Leaders
f.Employee Resource Group
g.None of the above

**277**  Who in your hospital or health care system is accountable for **implementing strategies** for health equity goals (Check all that apply)
a.CEO
b.Designated Senior Executive (Chief Diversity Officer, VP for DEI, etc.)
c.Middle Management
d.Committee or Task Force
e.Division/Department Leaders
f.Employee Resource Group
g.None of the above

**278**  Does your hospital or health care system use DEI (Diversity, Equity and Inclusion) disaggregated data to inform decisions on the following? (Check all that apply) (Disaggregated data refers to the separation of compiled information into smaller units to elucidate underlying trends and patterns.)
a.Patient Outcomes
b.Procurement
c.Supply Chain
d.Training
e.Professional Development
f.None of the above

**279**  Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply)
a.Equitable and inclusive organizational policies
b.Systematic and shared accountability for health equity
c.Diverse representation in hospital and health care system leadership
d.Diverse representation in hospital and health care system governance
e.Community engagement
f.Collection and use of segmented data to drive action
g.Culturally appropriate patient care
h.None of the above

## XIII. SUPPLEMENTAL INFORMATION

*280*    *Use this space or an additional sheet if more space is needed to elaborate on any of the information supplied on the survey. Refer to each response by page, section, and line number.*

# HOSPITAL FISCAL SURVEY TEMPLATE
## WHA Information Center

**NOTE:** Refer to the detailed instructions contained in the Fiscal Survey Manual.

This is a blank template to use to share the basic questions of the survey with other people in the organization in preparation for gathering all the necessary information to complete the online survey.

All survey data must be entered and submitted through the online secured portal. Each staff member completing a portion of the survey must have their own username and password. Click here for more information on roles and registration.

This information can also be printed from the survey portal.

*Disclaimer-the fiscal survey manual and the online portal contains the most accurate up-to-date information.

This template does not reference a specific year as all data is submitted through the online portal for the current year. Abbreviations Previous Fiscal Year denoted with PFY and Current Fiscal Year denoted with CFY.

### I. HOSPITAL INFORMATION
Hospital Name and Address


FY Beginning Date                              FY Ending Date

## II.     GENERAL INFORMATION

If your hospital is jointly operated in connection with a nursing home, home health agency, or other organization, and is governed by a common Board of Directors, the hospital shall submit the required information from the final audited financial statements of the **hospital only** except where such information cannot be disaggregated. **(See special instructions for combination facilities in the accompanying** *Hospital Fiscal Survey Manual).* All hospital services must be reported if they are included as hospital revenue and contained in net revenue from services to patients.   Refer to page 2 - line 3.

**1     Public Contact**  (provide First and Last Name of individual you want listed in the public data sets)

**2     Is your facility a combination facility?  (Enter Yes or No in the box.)**
        For definitions and instructions, see the *Hospital Fiscal Survey Manual.*

### STATEMENT OF REVENUE AND EXPENSES

**3     NET** REVENUE FROM SERVICES TO PATIENTS **(INCLUDING MEDICAID ACCESS PAYMENTS)** .......................................................................................... $ _____

**Other Revenue**

**4**    Tax appropriations ............................................................................. $ _____

**5**    All other operating revenue (including operating gains) ................ $ _____

**6**    TOTAL Other Revenue (add **only** lines 4 and 5; do **not** include line 3 in line 6) .................... $ _____

**7**    **TOTAL** REVENUE (add lines 3 and 6) ............................................................. $ _____

**Payroll Expenses**

**8**    Physicians and dentists .................................................................... $ _____

        Number of physicians employed _____     Number of physician FTEs _____
        Number of dentists employed     _____    Number of dentist FTEs     _____

**9**    Medical and dental residents and interns ........................................ $ _____

**10**
        Trainees ........................................................................................... $ _____

**11**   Registered nurses and licensed practical nurses ........................... $ _____

**12**  All other personnel .......................................................................... $ _____

**13**   TOTAL Payroll Expenses (add lines 8 through 12) ............................................ $ _____

**Nonpayroll Expenses**

**14**   Employee benefits (Social Security, group insurance, retirement benefits, etc.) .................................................................................................. $ _____

**15**   Professional fees (medical, dental, legal, auditing, consultant, etc.) ............ $ _____

**16**   Contracted nursing services (include staff from nursing registries and temporary help agencies) .................................................................. $ _____

**17**   Depreciation expense (for reporting period only) ........................... $ _____

**18**   Interest expense .............................................................................. $ _____

**19**   Medical malpractice insurance premiums ....................................... $ _____

**20**   Amortization of financing expenses ................................................ $ _____

**21** Rents and leases $\rule{3cm}{0.4pt}$ $ \rule{5cm}{0.4pt}

**22** Capital component of insurance premium $\rule{3cm}{0.4pt}$ $ \rule{5cm}{0.4pt}

**23** All other operating expenses – (including Medicaid assessments paid, supplies, purchased services, utilities, property taxes, etc., and operating loses) $ \rule{5cm}{0.4pt}

**24** TOTAL Nonpayroll Expenses (add lines 14 through 23) $\rule{6cm}{0.4pt}$ $ \rule{4cm}{0.4pt}

**25** **TOTAL** EXPENSES (add lines 13 and 24) $ \rule{4cm}{0.4pt}

**26** Excess (or deficit) of revenue over expenses (subtract line 25 from line 7; see manual) $ \rule{4cm}{0.4pt}

**Nonoperating Gains / Losses**

**27** Investment income $ \rule{5cm}{0.4pt}

**28** Other nonoperating gains (including extraordinary gains) $ \rule{5cm}{0.4pt}

**29** Provision for income taxes (for-profit organizations) (absolute values only – no negative values) $ \rule{5cm}{0.4pt}

**30** Other nonoperating losses (including extraordinary losses) (absolute values only – no negative values) $ \rule{5cm}{0.4pt}

**31** TOTAL Nonoperating Gains / Losses (subtract sum of lines 29 and 30 from sum of lines 27 and 28) $ \rule{4cm}{0.4pt}

**32** **NET** INCOME (revenue and gains in excess of expenses and losses) (add lines 26 and 31) $ \rule{4cm}{0.4pt}

## III. DETAIL OF PATIENT SERVICE REVENUE    (based on full established rates)

**Gross Patient Service Revenue and Its Sources**

**33** Gross revenue from room, board, and medical and nursing services to INPATIENTS $ \rule{4cm}{0.4pt}    (sum of lines 33 and 34 must equal sum of inpatient breakouts, lines 37-50)

**34** Gross INPATIENT ancillary revenue  = $ \rule{4cm}{0.4pt}

**35** Gross revenue from service to OUTPATIENTS $ \rule{4cm}{0.4pt}    (must equal sum of outpatient breakouts, lines 37-50)

**36** **TOTAL GROSS** revenue from service to patients $ \rule{4cm}{0.4pt}    (add lines 33-35)

NOTE: The following sources of gross patient revenue are by **TOTAL** dollar amounts and by separate **INPATIENT** and **OUTPATIENT** breakouts. *This section (Lines 37-51) has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

| *Public Sources* | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **37** Medicare | $ | $ | $ |
| **38** HMOs reimbursed by Medicare under 42 CFR pt. 417 | $ | $ | $ |
| **39** Medical Assistance (Including BadgerCare) | $ | $ | $ |

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| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **40** HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis. Stats ……. | $ | $ | $ |
| **41** OBSOLETE | $ | $ | $ |
| **42** County 51.42 / 51.437 programs | $ | $ | $ |
| **43** All other public programs | $ | $ | $ |

### Commercial Sources

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **44** Group and individual accident and health insurance, self-funded plans | $ | $ | $ |
| **45** Worker's compensation | $ | $ | $ |
| **46** HMOs and all other alternative health care payment systems (exclude lines 38 and 40) | $ | $ | $ |
| **47** Self-pay …………………………………….. | $ | $ | $ |

**All other sources (specify below):**

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **48** Other Payers 1 | $ | $ | $ |
| **49** Other Payers 2 | $ | $ | $ |
| **50** OBSOLETE | $ | $ | $ |
| **51** Total Gross revenue from service to patients, by source (add lines 37-50, should equal value on line 36) .…...…… | $ | $ | $ |

### Deductions from Patient Service Revenue and Its Sources

NOTE: Contractual Adjustments are by **TOTAL** dollar amounts **and** by separate **INPATIENT** and **OUTPATIENT** breakouts. *This section (Lines 52-69) has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

### Public Source Contractual Adjustments

| | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **52** Medicare | $ | $ | $ |
| **53** HMOs reimbursed by Medicare under 42 CFR pt. 417 | $ | $ | $ |
| **54** Medical Assistance (include effect of enhanced Medical Assistance payments) | $ | $ | $ |
| **55** HMOs reimbursed by Medical Assistance under s. 49.45 (3) (b), Wis Stats. (include effect of enhanced Medical Assistance payments) | $ | $ | $ |
| **56** OBSOLETE | $ | $ | $ |
| **57** County 51.42 / 51.437 programs | $ | $ | $ |

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58   All other public programs   ---------------------   $ _____   $ _____   $ _____

*Commercial Source Contractual Adjustments*

59   Group and individual accident and
     health insurance, self-funded plans   -------------   $ _____   $ _____   $ _____

60   Worker's compensation   ---------------------   $ _____   $ _____   $ _____

| | **TOTAL** | **INPATIENT** | **OUTPATIENT** |
|---|---|---|---|
| 61  HMOs and all other alternative health care payment systems (exclude lines 53 and 55) | $ _____ | $ _____ | $ _____ |
| 62  Self-Pay | $ _____ | $ _____ | $ _____ |

*Other Source Contractual Adjustments*
All other sources (specify below)

63   Other Adjustments 1 _____   $ _____   $ _____   $ _____

64   Other Adjustments 2 _____   $ _____   $ _____   $ _____

65   Other Adjustments 3 _____   $ _____   $ _____   $ _____

*Charity Care / Bad Debt*

66   Charity care (revenue foregone at full
     established rates) (must equal line 123)   -----   $ _____   $ _____   $ _____

67   Bad Debt   ---------------------------   $ _____   $ _____   $ _____

68   All other noncontractual deductions   -------------   $ _____   $ _____   $ _____

69   **TOTAL** DEDUCTIONS FROM
     REVENUE   ----------   $ _____   $ _____   $ _____
                (add lines 52-68) (total, not breakouts)

**Medicare-Approved Medical Education Activities**
      NOTE:  Of TOTAL expenses in line 25, the reimbursable expenses for Medicare-approved medical education activities separated
      into the following categories:

70   Direct medical education expenses   ------------------------------------------------   $ _____

71   Indirect medical education expenses   ------------------------------------------------   $ _____

72   **TOTAL** reimbursable expenses for Medicare-approved
     medical education activities (add lines 70 and 71)   ------------------------------------------------   $ _____


**IV.      BALANCE SHEET – GENERAL FUNDS**
      NOTE: For combination facilities, state-operated mental health institutes, or county-operated psychiatric or alcohol or other
      drug abuse hospitals, see special instructions in the *Hospital Fiscal Survey Manual*.
**Unrestricted Assets** (recorded on the balance sheet at the end of each reporting period)
      **Current Assets**
73   Cash and cash equivalents   ------------------------------------------------   $ _____

74   Inter-corporate account(s)   ------------------------------------------------   $ _____


626

### Net patient accounts receivable

75   Medicare (T18) -Including HMOs reimbursed by T-18 *   $ _____

76   Medical Assistance (T-19)- Including HMOs reimbursed by T-19 *   $ _____

77   Self-Pay*   $ _____

78   All other pay sources*   $ _____

79   Total Net patient accounts receivable (add lines 75 thru 78)   $ _____

80   Other accounts receivable   $ _____

81   Other current assets   $ _____

82   **TOTAL** current assets (add lines 73 through 81)   $ _____

83   Noncurrent assets whose use is limited   $ _____

**Property, Plant and Equipment**
**Gross Plant Assets**

84   Land   $ _____

85   Land improvements   $ _____

86   Buildings and building improvements   $ _____

87   Construction in progress   $ _____

88   Fixed equipment   $ _____

89   Moveable equipment   $ _____

90   **TOTAL** gross plant assets (add lines 84 through 89)   $ _____

**LESS Accumulated Depreciation** (absolute values only – no negative values)

91   Land improvements   $ _____

92   Buildings and building improvements   $ _____

93   Fixed equipment   $ _____

94   Moveable equipment   $ _____

95   **TOTAL** accumulated depreciation (add lines 91 through 94)   $ _____

96   **NET** property, plant, and equipment assets (subtract line 95 from line 90)   $ _____

97   Long-term investments   $ _____

98   Other unrestricted assets   $ _____

99   **TOTAL** unrestricted assets (add lines 82, 83, 96, 97 and 98)   $ _____

**Unrestricted Liabilities, Deferred Revenues, and Fund Balances**

100   Current liabilities   $ _____

101   Inter-corporate account(s)   $ _____

102   Long-term debt   $ _____

103   Other noncurrent liabilities and deferred revenues   $ _____

104   Fund balances   $ _____

105   TOTAL unrestricted liabilities, deferred revenues, and fund balances (add lines 100 through 104).
(**NOTE:** lines 99 and 105 should be equal. Combination facilities, see manual instructions)   $ _____

**Restricted Hospital Funds** (report fund balances only)

**106** Specific-purpose funds _____ $ _____

**107** Plant replacement and expansion funds _____ $ _____

**108** Endowment funds _____ $ _____


**V.      HOSPITAL INPATIENT UTILIZATION BY PAY SOURCE** (for current reporting period)

| | (A1)<br><br>NUMBER OF INPATIENT DISCHARGES** | (A2)<br><br>NUMBER OF DISCHARGE DAYS** | (B1)<br><br>NUMBER OF NEWBORNS*** | (B2)<br><br>NUMBER OF NEWBORN DISCHARGE DAYS*** |
|---|---|---|---|---|
| **PAY SOURCE** | | | | |
| **109** Medicare (T-18)<br>Including HMOs reimbursed by T-18 | _____ | _____ | _____ | _____ |
| **110** Medical Assistance (T-19)<br>Including HMOs reimbursed by T-19 | _____ | _____ | _____ | _____ |
| **111** Self-Pay | _____ | _____ | _____ | _____ |
| **112** All other pay sources | _____ | _____ | _____ | _____ |
| **113** **TOTALS** | _____ | _____ | _____ | _____ |

** This figure should include all inpatients discharged during the reporting period. Report the number of adult, pediatric, and intensive and intermediate care neonatal patients (including deaths).   Exclude newborn, Medicare-certified swing bed, and hospital unit transfer patients.

*** Exclude fetal deaths.

| | (C1)<br><br>NUMBER OF DISCHARGES<br><br>FROM MEDICARE-CERTIFIED SWING BEDS**** | (C2)<br><br>NUMBER OF DISCHARGE DAYS FROM MEDICARE-CERTIFIED SWING BEDS**** |
|---|---|---|
| **PAY SOURCE** | | |
| **114** Medicare (T-18)<br>Including HMOs reimbursed by T-18 | _____ | _____ |
| **115** Medical Assistance (T-19)<br>Including HMOs reimbursed by T-19 | _____ | _____ |
| **116** Self- Pay | _____ | _____ |
| **117** All other pay sources | _____ | _____ |
| **118** **TOTALS** | _____ | _____ |

## VI. SUMMARY AND EXPLANATION OF REVENUE DOLLAR DIFFERENCES BETWEEN PREVIOUS FY AND CURRENT FY

|  | GROSS REVENUE | NET REVENUE |
|---|---|---|
| **119** Current Fiscal Year [line 36 (gross) and line 3 (net)] | $ _____ | $ _____ |
| **120** Previous Fiscal Year line 36 (gross) and line 3 (net)] | $ _____ | $ _____ |
| **121** Increase / Decrease CFY v. PFY (subtract line 120 from line 119) [indicate + or -] | $ _____ | $ _____ |

**122** **Explain** in a short narrative the relative importance of various causes for the dollar differences (lines 119 and 120) in the fiscal year revenue figures (price change, utilization change, other causes?). Attach additional page(s) if necessary.

## VII. UNCOMPENSATED HEALTH CARE

*This section (Lines 125 and 127) has data elements that are used to calculate the percentage of charges that are collected by the facility. These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

**Charges for Uncompensated Health Care**

|  | CFY | CFY (Projected) |
|---|---|---|
| **123** Charges for charity care provided for the fiscal year | $ _____ (from line 66) | $ _____ |
| **124** Charity care cost (using hospital cost to charge ratio) | $ _____ | $ _____ |
| **125** Charges determined to be a bad debt for the fiscal year …. | $ _____ (from line 67) | $ _____ |
| **126** Bad debt cost (using hospital cost to charge ratio) | $ _____ | $ _____ |
| **127** **TOTAL** charges for uncompensated health care for the fiscal year …. | $ _____ (add lines 123 and 125) | $ _____ (add lines 123 and 125) |
| **128** Total cost (using hospital cost to charge ratio) | $ _____ | $ _____ |
| **129** Hospital cost-to-charge ratio (used for calculations of lines 124, 126 and 128) (e.g. .458) | _____ |  |

**Number of "Patients" Receiving Uncompensated Health Care**

(See manual for definitions – the number of "patients" should be reported as the number of individual patient visit ledgers.)

|  | CFY | CFY (Projected) |
|---|---|---|
| **130** Number of individual patient visit ledgers that received charity care for the fiscal year ……………………………………………………… | _____ | _____ |
| **131** Number of individual patient visit ledgers whose charges were determined to be bad debt for the fiscal year …………………….. | _____ | _____ |

**132**  Provide a **rationale** for the hospital's current fiscal year projections in the space below.  Explain how the projections used "patients" and total charges for current fiscal year, if at all.  It could also include a description of the socioeconomic climate of your hospital's market and how that affects your hospital's Uncompensated Health Care Plan.  Attach additional page(s) if necessary. (Using cost to charge ratio)

### Hill-Burton Uncompensated Health Care Information

**133**  Does the hospital have current obligations under this program?
Enter Yes, No, or C (for conditional) on this line _____    _____

**134**  If YES, enter date(s) the obligation(s) went into effect and date(s) the obligation(s) will be satisfied.

| Effective beginning date(s) | Projected satisfaction date(s) |
|---|---|
| Month / Year | Month / Year |
| Month / Year | Month / Year |
| Month / Year | Month / Year |

**135**  If YES, enter the amount of total federal assistance believed to remain under obligation.    …………...  $ _____

### WISCONSIN HOSPITAL MEDICAL ASSISTANCE (MA) ASSESSMENT PROGRAM

*This section has a data element that is used to calculate the percentage of charges that are collected by the facility.  These calculated percentages are displayed on WHA Information Center's PricePoint Web site.*

|  | TOTAL |
|---|---|
| **136** Medicaid Assistance assessments paid to State of Wisconsin | $ _____ |

| PAY SOURCE | TOTAL | INPATIENT | OUTPATIENT |
|---|---|---|---|
| **137** Enhanced MA fee-for-service payments **(estimates)** | $ _____ | $ _____ | $ _____ |
| **138** Actual access payments received through HMOs Reimbursed by Medical Assistance under Ch. 49, Wis. Stats. | $ _____ | $ _____ | $ _____ |
| **139** TOTAL MA reimbursement  enhancements | $ _____ | $ _____ | $ _____ |